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March 26, 2013

Mr. Roy Hess
Deputy Director
Finance and Administration Department of Health and Human Services
1801 Main Street
Columbia, SC 29202-8206

[sent via email: hessroy@scdhhs.gov]

Re: April 2012 – March 2013 MCO Rate Calculation and Certification

Dear Roy:

Thank you for the opportunity to assist the South Carolina Department of Health and Human Services with this important project. Our report summarizes the development and actuarial certification of the April 2012 – March 2013 capitation rates for the South Carolina Medicaid managed care program.

The final report includes the following changes from the March 6, 2012 draft rate report:

- > Included an adjustment to reflect the increased limits for adolescent well visits
- > Revised MCO selection factor for TANF children and TANF adults based on updated enrollment information
- > Reduced the magnitude of the managed care savings factors applied to FFS physician services

Please call me at 262-796-3434 if you have questions.

Sincerely,

John D. Meerschaert, FSA, MAAA
Principal and Consulting Actuary

JDM/vrr

Attachments



**State of South Carolina
Department of Health and Human Services
April 2012 – March 2013
Capitation Rate Development for
Medicaid Managed Care Program**

Prepared for:
**The State of South Carolina
Department of Health and Human Services**

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I. EXECUTIVE SUMMARY

This report documents the development of April 2012 – March 2013 managed care organization (MCO) capitation rates for South Carolina’s Medicaid managed care program. The South Carolina Department of Health and Human Services (SC DHHS) retained Milliman to calculate, document, and certify its capitation rate development. We developed the capitation rates using the methodology described in this report. Our role is to certify that the April 2012 – March 2013 capitation rates produced by the rating methodology are actuarially sound to comply with CMS regulations.

APRIL 2012 – MARCH 2013 CAPITATION RATES AND ACTUARIAL CERTIFICATION

Table 1 shows the statewide rate change from the July 2011 – March 2012 MCO capitation rates to the April 2012 – March 2013 capitation rates. Table 1 shows the rate changes including and excluding the supplemental teaching payments since the payments are a pass-through to providers.

Table 1			
South Carolina Department of Health and Human Services			
April 2012 – March 2013 Capitation Rate Change			
Based on October 2011 Enrollment by Rate Cell			
	July 2011 – March 2012 Rate	April 2012 – March 2013 Rate	Percentage Change
Including Supplemental Teaching Payments			
Ethically Limited Services	\$227.36	\$239.08	5.2%
Standard Services	302.31	312.96	3.5%
Total	\$264.25	\$275.44	4.2%
Excluding Supplemental Teaching Payments			
Ethically Limited Services	\$218.66	\$228.44	3.5%
Standard Services	291.06	299.31	2.8%
Total	\$254.29	\$263.32	3.5%

Note the MCOs covering ethically limited services and the MCOs covering standard services have materially different enrollment distributions by rate cell.

The 3.5% change in MCO capitation rates from July 2011 – March 2012 to April 2012 – March 2013 can be broken down as follows:

- > 2.0% increase for the same population and benefit package,
- > 0.3% increase to restore an underpayment in the July 2011 – March 2012 rates due to the underreporting of maternity kicker payments in the average administrative allowance calculation,
- > 1.1% decrease due to a reduction in the administrative allowance from 10.5% to 9.5% of MCO revenue (excluding supplemental teaching payments),
- > 0.6% increase due to increased acuity of MCO members, and
- > 1.7% increase due to the additional services added to the MCO contract on April 1, 2012.

Table 2 compares the rate cell specific changes including supplemental teaching payments.

Table 2			
South Carolina Department of Health and Human Services			
April 2012 – March 2013 Capitation Rates – Including Supplemental Teaching Payments			
Ethically Limited Services			
Rate Cell	July 2011 – March 2012 Rates	April 2012 – March 2013 Rates	Percent Change
TANF: 0 - 2 months old	\$1,451.90	\$1,961.49	35.1%
TANF: 3 - 12 months old	244.04	236.20	-3.2%
TANF: Age 1 - 6	102.05	118.26	15.9%
TANF: Age 7 - 13	94.06	105.47	12.1%
TANF: Age 14 - 18 Male	109.93	111.93	1.8%
TANF: Age 14 - 18 Female	138.43	139.62	0.9%
TANF: Age 19 - 44 Male	289.55	252.81	-12.7%
TANF: Age 19 - 44 Female	339.91	330.85	-2.7%
TANF: Age 45+	564.49	540.87	-4.2%
SSI – Children	733.78	409.20	-44.2%
SSI – Adult	733.78	888.80	21.1%
OCWI	396.32	399.26	0.7%
Duals	152.39	125.99	-17.3%
Maternity Kicker Payment	5,364.13	4,970.61	-7.3%
Standard Services			
Rate Cell	July 2011 – March 2012 Rates	April 2012 – March 2013 Rates	Percent Change
TANF: 0 - 2 months old	\$1,451.90	\$1,961.49	35.1%
TANF: 3 - 12 months old	244.04	236.20	-3.2%
TANF: Age 1 - 6	102.05	118.27	15.9%
TANF: Age 7 - 13	94.18	105.61	12.1%
TANF: Age 14 - 18 Male	109.95	111.95	1.8%
TANF: Age 14 - 18 Female	145.37	148.86	2.4%
TANF: Age 19 - 44 Male	289.78	253.04	-12.7%
TANF: Age 19 - 44 Female	349.65	344.06	-1.6%
TANF: Age 45+	565.49	542.01	-4.2%
SSI – Children	735.31	410.24	-44.2%
SSI – Adult	735.31	890.49	21.1%
OCWI	416.62	428.69	2.9%
Duals	152.63	126.30	-17.3%
Maternity Kicker Payment	5,669.33	5,164.06	-8.9%

Table 3 compares the rate cell specific changes excluding supplemental teaching payments.

Table 3			
South Carolina Department of Health and Human Services			
April 2012 – March 2013 Capitation Rates – Excluding Supplemental Teaching Payments			
Ethically Limited Services			
Rate Cell	July 2011 – March 2012 Rates	April 2012 – March 2013 Rates	Percent Change
TANF: 0 - 2 months old	\$1,366.33	\$1,844.62	35.0%
TANF: 3 - 12 months old	224.33	214.69	-4.3%
TANF: Age 1 - 6	97.66	112.52	15.2%
TANF: Age 7 - 13	90.97	101.59	11.7%
TANF: Age 14 - 18 Male	106.42	107.04	0.6%
TANF: Age 14 - 18 Female	133.18	133.23	0.0%
TANF: Age 19 - 44 Male	280.39	245.23	-12.5%
TANF: Age 19 - 44 Female	330.17	318.74	-3.5%
TANF: Age 45+	551.50	523.52	-5.1%
SSI – Children	707.41	376.36	-46.8%
SSI – Adult	707.41	857.63	21.2%
OCWI	361.11	363.15	0.6%
Duals	135.71	112.85	-16.8%
Maternity Kicker Payment	5,364.13	4,970.61	-7.3%
Standard Services			
Rate Cell	July 2011 – March 2012 Rates	April 2012 – March 2013 Rates	Percent Change
TANF: 0 - 2 months old	\$1,366.33	\$1,844.62	35.0%
TANF: 3 - 12 months old	224.33	214.69	-4.3%
TANF: Age 1 - 6	97.66	112.52	15.2%
TANF: Age 7 - 13	91.09	101.73	11.7%
TANF: Age 14 - 18 Male	106.44	107.06	0.6%
TANF: Age 14 - 18 Female	140.05	142.20	1.5%
TANF: Age 19 - 44 Male	280.61	245.46	-12.5%
TANF: Age 19 - 44 Female	339.73	331.57	-2.4%
TANF: Age 45+	552.49	524.65	-5.0%
SSI – Children	708.91	377.35	-46.8%
SSI – Adult	708.91	859.24	21.2%
OCWI	380.41	390.82	2.7%
Duals	135.95	113.15	-16.8%
Maternity Kicker Payment	5,669.33	5,164.06	-8.9%

Appendices A – E document the development of the April 2012 – March 2013 capitation rates. Appendices F and G show the breakdown of the April 2012 – March 2013 capitation rates by major service category. Appendix H calculates the fiscal impact of the April 2012 – March 2013 capitation rates. Appendix I contains our actuarial certification.

The actuarial certification of the April 2012 – March 2013 Medicaid managed care capitation rates is included as Appendix I. It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Actual costs will be dependent on each contracted MCO's situation and experience.

Section II of the report provides a short background regarding South Carolina's Medicaid managed care program. Section III documents the South Carolina Medicaid managed care capitation rate methodology. Section IV of the report provides information regarding the assignment of service categories. Section V discusses issues related to the CMS rate setting checklist.

DATA RELIANCE AND IMPORTANT CAVEATS

We used fee-for-service cost, MCO encounter data cost, and eligibility data for April 2010 through March 2011, historical reimbursement information, fee schedules, and several provider reimbursement analyses to calculate the South Carolina Medicaid managed care capitation rates shown in this report. This data was provided by SC DHHS. We have not audited or verified this data and other information. If the underlying data or information is inaccurate or incomplete, the results of our analysis may likewise be inaccurate or incomplete. We performed a limited review of the data used directly in our analysis for reasonableness and consistency and have not found material defects in the data. If there are material defects in the data, it is possible that they would be uncovered by a detailed, systematic review and comparison of the data to search for data values that are questionable or for relationships that are materially inconsistent. Such a review was beyond the scope of our assignment.

In order to provide the information requested by SC DHHS we have constructed several projection models. Differences between the capitation rates and actual experience will depend on the extent to which future experience conforms to the assumptions made in the capitation rate calculations. It is certain that actual experience will not conform exactly to the assumptions used. Actual amounts will differ from projected amounts to the extent that actual experience is better or worse than expected.

Milliman prepared this report for the specific purpose of developing April 2012 – March 2013 Medicaid managed care capitation rates. This report should not be used for any other purpose. This report has been prepared solely for the internal business use of and is only to be relied upon by the management of SC DHHS. We anticipate the report will be shared with contracted MCOs and other interested parties. Milliman does not intend to benefit or create a legal duty to any third party recipient of its work. It should only be reviewed in its entirety.

The results of this report are technical in nature and are dependent upon specific assumptions and methods. No party should rely on these results without a thorough understanding of those assumptions and methods. Such an understanding may require consultation with qualified professionals.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all actuarial communications. The authors of this report are members of the American Academy of Actuaries, and meet the qualification standards for performing the analyses in this report.

The terms of Milliman's contract with SC DHHS dated July 1, 2011 apply to this report and its use.

II. BACKGROUND

Medicaid health plans have been operating in South Carolina since 1996. In August 2007, SC DHHS implemented the South Carolina Healthy Connections Choices program to more effectively enroll members in health plans. When members enroll, they choose a health plan and a doctor (or clinic). Healthy Connections Choices helps members choose a health plan that is best for them.

With the help of health plans and enrollment counselors, SC DHHS seeks to increase care coordination and disease prevention methods not found in traditional fee-for-service Medicaid. Those who choose to enroll in a health plan also will establish crucial relationships with a primary care physician (PCP). Under fee-for-service, many Medicaid beneficiaries are left to navigate the health care system on their own, leading many to seek only sporadic care or emergency services.

Under South Carolina Healthy Connections Choices, participants receive the same benefits as those in traditional Medicaid, and also extra services offered through the health plans. These extra services may include benefits such as unlimited doctor visits, eyeglasses and dental care for adults, smoking cessation classes, and programs tailored for those with specific diseases.

There are two categories of Medicaid health plans in South Carolina: traditional Managed Care Organizations (MCOs) and Medical Home Networks (MHNs).

The MHN program is a primary care case management program and is composed of a Care Coordination Services Organization (CSO) and the PCPs enrolled in that network. The CSO supports the physicians and enrolled members by providing care coordination, disease management, and data management. The PCPs manage the health care of their members, which includes authorizing services, provided by other health care providers.

There are currently four MCOs and three MHNs participating in the South Carolina Medicaid program.

III. METHODOLOGY AND RESULTS

This section of the report describes the April 2012 – March 2013 South Carolina Medicaid managed care capitation rate methodology.

CHANGES FOR THE APRIL 2012 – MARCH 2013 RATE UPDATE

The April 2012 – March 2013 capitation rate methodology reflects several changes to the July 2011 – March 2012 rate methodology. The changes are listed and described below.

Use of MCO Encounter Data for Rate Setting:

The April 2012 – March 2013 rate methodology relies on April 2010 – March 2011 MCO encounter data as the primary data source. We also used April 2010 – March 2011 FFS data for MCO enrollees for services that were not part of the MCO contract during the April 2010 – March 2011 base period and to develop the dual eligible rate.

In-Rate Criteria:

SC DHHS implemented several changes to services covered by the MCOs through the In-Rate Criteria definition. The changes are effective April 1, 2012 and are implemented in the April 2012 – March 2013 capitation rates. The changes are as follows:

- > Licensed Independent Professional Services (LIPS)
- > Mental Health related hospital outpatient services are added as MCO covered services.
- > Psychiatric diagnostic and evaluative interview procedures are added as MCO covered services

The detailed description the newly added MCO covered services is provided later in this report.

Long Term Care Benefit Limit:

Starting on April 1, 2012, MCOs will be required to cover enrollees for services during the first ninety (90) continuous days of confinement in a long term care facility and until they can be disenrolled from the MCO instead of the first thirty (30) days in the previous rate period.

Services include nursing facility and rehabilitative services at the skilled, intermediary, or sub-acute level of care. MCO enrollment will not be terminated in the middle of a month; therefore, MCOs will be required to cover contract services through the end of the month in which the 90 day stay is reached. Disenrollment will typically occur at the earliest edit date after the 90 continuous day confinement has been reached (an average of 105 days after nursing home admission).

The detailed description of the methodology used to account for this benefit expansion is provided later in this report.

SSI Rate Cell Split:

Starting on April 1, 2012, the SSI rate cell will be split into SSI Children and SSI Adults. Individuals assigned to the SSI rate cell age 19 and over will be assigned to the SSI Adult rate cell while those under the age of 19 will be assigned to the SSI Children rate cell.

BASE DATA

The April 2012 – March 2013 rate methodology relies on April 2010 – March 2011 MCO encounter data as the primary data source. We also used April 2010 – March 2011 FFS data for MCO enrollees for services that were not part of the MCO contract during the April 2010 – March 2011 base period and to develop the dual eligible rate. Until recently, the MCO encounter data had not been fully validated and was not ready for use in the rate setting process. Milliman has been assisting SC DHHS with the development of an encounter monitoring report that has been utilized in the contract between SC DHHS and the managed care organization. Through this reporting process, we determined that the encounter data was ready for use in the rate setting process.

RETROACTIVE ELIGIBILITY PERIODS AND ENROLLMENT LAG

Recipient enrollment in the fee-for-service program can and does occur retroactively. When an individual applies and qualifies for Medicaid coverage, SC DHHS reimburses claims which occurred during the retroactive qualification period prior to their application. There is a lag between the first date of eligibility and the date of enrollment in an MCO. Once a Medicaid recipient signs up for an MCO, they will be enrolled on the first day of the subsequent month. The retroactive enrollment period is not covered by the MCO.

Because the retroactive enrollment period is not included in the MCO encounter data, an adjustment is not necessary.

ELIGIBILITY CATEGORY ASSIGNMENT

The assignment of payment categories to eligibility category was provided by SC DHHS and is summarized in Table 4 below.

Table 4 South Carolina Department of Health and Human Services Eligibility Category Assignment	
Payment Category Code	Eligibility Category
11	TANF
12	TANF
13	TANF
30	TANF
31	TANF
51	TANF
58	TANF
59	TANF
60	TANF
68	TANF
88	TANF
91	TANF
87	OCWI
Other	SSI

Not all Medicaid recipients are eligible to enroll in the Medicaid managed care program as defined by Payment Categories and Waiver programs. Table 5 below shows the ineligible payment categories.

Table 5 South Carolina Department of Health and Human Services Excluded Payment Category Codes			
Payment Category	Description	Payment Category	Description
10	MAO (Nursing Home)	50	Qualified Working Disabled
14	MAO (General Hospital)	52	SLMB
15	MAO (CLTC Waiver)	54	SSI Nursing Home
33	ABD Nursing Home	55	Family Planning
41	Reinstatement	56	COSY / ISCEDC
42	Silver Card and SLMB	70	Refugee Entrant
43	Silver Card and S2 SLMB	90	QMB
48	S2 SLMB	92	Silver Card
49	S3 SLMB		

Although there should be no individuals in those payment categories enrolled in an MCO, the payment categories can be assigned retroactively.

MCO PROGRAMS WITH ETHICAL LIMITATIONS

MCOs offering the ethically limited benefit package are bound to abide by the principles set forth in the Ethical and Religious Directives for Catholic Health Care Services promulgated by the National Conference of Catholic Bishops. In accordance with their ethical obligations, certain MCOs shall not provide, support or participate in the delivery of any services, including family planning services, which are inconsistent with such directives. This limitation precludes certain MCOs from performing case management, quality management, utilization review services, and claims processing in relation to family planning services.

Family planning services are defined as all services (including counseling), procedures, devices, and medications for the purpose of infertility treatment or for the purpose of preventing or terminating pregnancy including temporary and permanent sterilization procedures, such as tubal ligation, vasectomy procedures, and abortions. All family planning services are subject to the Ethical Limitations.

Consistent with prior years, capitation rates are calculated separately for the Ethically Limited benefit package and Standard benefit package. The cost associated with family planning services is explicitly categorized in the attached appendices. The following appendices show the Family Planning Add-On development:

- > Appendix A2
- > Appendix B2

We calculated a Family Planning Add-On only for those rate cells that are expected to incur family planning and related services that are excluded from services offered by MCOs subject to ethical limitations. The following rate cells have different rates for the standard and ethically limited benefit package:

- > TANF: Age 7 – 13
- > TANF: Age 14 – 18 Male
- > TANF: Age 14 – 18 Female
- > TANF: Age 19 – 44 Male
- > TANF: Age 19 – 44 Female
- > TANF: Age 45+
- > SSI - Children
- > SSI - Adult
- > OCWI
- > Duals
- > Maternity Kicker Payment

The ethically limited capitation rates for the other rate cells are equal to the rates calculated for the standard benefit package.

CAPITATION RATE METHODOLOGY

The methodology used to calculate the medical component of the capitation rates can be outlined in the following steps:

1. Extract encounter and fee-for-service experience data for the Medicaid managed care eligible population by eligibility category.
2. Apply adjustments to reflect April 2012 – March 2013 contract period.
3. Calculate estimated April 2012 – March 2013 managed care costs by eligibility category and adjust for administrative expenses and supplemental teaching payments.
4. Adjust TANF and SSI rates for MCO specific risk scores.

Each of the above steps is described in detail below.

Step 1: Extract Encounter and Fee-For-Service Experience Data

In this step the encounter and fee-for-service experience data for April 2010 through March 2011 is summarized by eligibility category and service category for populations enrolled in the Medicaid MCOs.

Appendix A1 shows the MCO encounter experience data for the core services covered during the April 2010 through March 2011 contract period. Due to difficulties in identifying the Medicaid portion of the cost associated with retroactive dual eligibles, the base experience data for the dual eligible rate cell is the April 2010 – March 2011 fee-for-service data for dual eligibles enrolled in the FFS program.

Appendix A2 shows the MCO encounter experience data for the family planning services covered during the April 2010 through March 2011 contract period. The base experience data for the dual eligible rate cell is the April 2010 – March 2011 fee-for-service data for dual eligibles enrolled in the FFS program.

Appendix A3 shows the fee-for-service experience data for the services now covered by the MCOs that were not covered by the MCOs during the April 2010 through March 2011 contract period. Appendix A3 uses fee-for-service data for the population enrolled in MCOs during April 2010 – March 2011. The base experience data for the dual eligible rate cell is the April 2010 – March 2011 fee-for-service data for dual eligibles enrolled in the FFS program. The newly covered services are as follows:

- > General mental health hospital inpatient admissions. Since April 2011, MCOs have been responsible for admissions with DRGs 424 - 433 and 521 - 523 billed by general hospitals (Provider Type 01, Category of Service 01).
- > Licensed Independent Professional Services (LIPS). Identified as services billed by the following provider type and specialty combinations:
 - Provider Type / Provider Specialty 19 / 82
 - Provider Type / Provider Specialty 19 / SW
 - Provider Type / Provider Specialty 19 / PC
 - Provider Type / Provider Specialty 19 / LT

- Excluding claims billed with a prior authorization number beginning with the following 2-digit prefixes:
 - MH: Department of Mental Health,
 - ED: Department of Education,
 - CC: Continuum of Care for Emotionally Disturbed Children,
 - SS: Department of Social Services,
 - MR: Department of Disabilities and Special Needs,
 - YS: Department of Juvenile Justice, and
 - PP: Interagency System of Care for Emotionally Disturbed Children (ISCEDC)
- > Mental Health related hospital outpatient services. These services were previously excluded from the MCO capitation rate due to the claim having a Class C diagnostic code as the primary diagnostic code.
- > Psychiatric diagnostic and evaluative interview procedures. These services were previously excluded from the MCO capitation rates using the following criteria:
 - Provider Type: 19, Provider Specialty: 86, Procedures code in (90804 - 90829, 90847, 90853, 90862, 90882), Modifier = 000
 - Provider Type: 20 or 21, Provider Specialty: Any, Procedures code in (90804 - 90829, 90847, 90853, 90862, 90870, 90882, 90887, 90899), Modifier = 000
 - Provider Type: 20 or 21, Provider Specialty: Any, Procedures code in (90804, 90806, 90847, 90853), Modifier in (0HN, HN, 0HO, HO, 0HP, HP)
 - Provider Type: 22, Provider Specialty: (95, 96, 51, 21, 50, 58, 93, 94, 97, 98), Procedure Code: T1015, Modifier in (0HE, HE)
 - Provider Type: 20 or 21, Provider Specialty: Any, Procedure Code: 96101, Modifier in (HP, 0HP, 000)

Appendix A4 shows the fee-for-service experience data for the MCO services incurred during days 30 to 90 of confinement in a long term care facility and until MCO enrollees can be disenrolled from the MCO. Because disenrollment typically occurs at the earliest edit date after the 90 continuous day confinement has been reached, MCOs could be responsible for up to 105 days after nursing home admission due to the timing of disenrollment from a MCO.

Step 2: Apply Adjustment Factors to Reflect April 2012 – March 2013 Contract Period

In this step we apply adjustment factors to reflect differences between the April 2010 – March 2011 base period and the April 2012 – March 2013 MCO contract period. Each adjustment factor is explained in detail below.

Appendices B1 – B4 show the impact of the Step 2 adjustments.

Adolescent Wellness Visit Add-On:

SC DHHS is increasing the limit for adolescent well visits in order to improve certain HEDIS measures. The current policy provides coverage of well visits as follows:

- > Infant (birth through 11 months): 5 visits (using CPT 99381 or 99391)
- > Age 1 – 4: 6 visits (using CPT 99382 or 99392)
- > Age 5 – 11: 4 visits (using CPT 99383 or 99393)
- > Age 12 – 17: 3 visits (using CPT 99384 or 99394)
- > Age 18 – 21: 2 visits (using CPT 99385 or 99395)

SC DHHS is increasing the covered number of visits for adolescents as follows:

- > Age 5 – 11: 6 visits (using CPT 99383 or 99393)
- > Age 12 – 17: 6 visits (using CPT 99384 or 99394)
- > Age 18 – 21: 4 visits (using CPT 99385 or 99395)

The adolescent well visit add-on is developed by adjusting that actual encounter data for those services by the ratio of the new benefit limit to the current benefit limit. This approach ensures that the capitation rate are fully funded for the increased benefit cost.

IBNR Adjustment:

The encounter data used in developing the Medicaid managed care rates includes claims paid through October 31, 2011 allowing for seven months of run-out for the April 2010 – March 2011 base experience period. The fee-for-service data portion includes claims paid through December 31, 2011 allowing for nine months of run-out. The Incurred But Not Reported (IBNR) adjustment reflects an estimate of the claims that will be paid after the last payment dates for April 2010 – March 2011 incurred claims.

We used Milliman's *Claim Reserve Estimation Workbook (CREW)* to calculate the adjustment factors shown in Appendices B1 - B4. CREW calculates incurred but not reported (IBNR) reserve estimates by blending two different estimation methods: the lag completion method and the projection method.

The lag method reflects the historical average lag between the time a claim is incurred and the time it is paid. In order to measure this average lag, claims are separated by month of incurral and month of payment. Using this data, historical lag relationships are used to estimate ultimate incurred claims (i.e., total claims for a given incurral month after all claims are paid) for a specific incurral month based on cumulative paid claims for each month.

The projection method develops estimates for incurred claims in recent incurral months by trending an average base period incurred cost per unit to the midpoint of the incurred month at an assumed annual trend rate, and applying an additional factor to account for the seasonality of claim costs and the differing number of working days between months. The base period is chosen by selecting a group (usually 12) of recent consecutive months for which the lag completion method provides reasonable results.

The lag completion and projection methods are combined to produce the final incurred claim estimate. Final incurred claim estimates are calculated as a weighted average of these two methods. Completion factors were developed separately for the encounter and fee-for-service base experience periods.

Table 6 below shows the IBNR adjustment factors by eligibility group and major service category.

Table 6 South Carolina Department of Health and Human Services Incurred But Not Reported Adjustment Factors					
Eligibility Category	Inpatient Services	Outpatient Services	Physician Services	Prescription Drugs	Ancillary Services
Encounter Base Data					
TANF	1.007	1.009	1.005	1.000	1.006
SSI	1.011	1.009	1.009	1.000	1.006
OCWI	1.004	1.012	1.003	1.000	1.002
Duals	N/A	N/A	N/A	N/A	N/A
Kick	1.003	1.000	1.004	N/A	N/A
Fee-For-Service Base Data					
TANF	1.000	1.004	1.001	1.000	1.000
SSI	1.002	1.007	1.001	1.000	1.000
OCWI	1.000	1.000	1.000	1.000	1.000
Duals	1.015	1.012	1.011	1.000	1.022
Kick	N/A	N/A	N/A	N/A	N/A

Cost Sharing

South Carolina's fee-for-service Medicaid program includes several member copayment amounts that MCO members are now required to pay. Prior to April 1, 2011, MCO capitation rates assumed that MCO members were not required to pay copayment amounts. On May 1, 2011, the South Carolina Department of Health and Human Services (SCDHHS) increased the amount of beneficiary copayments.

Table 7 below shows the original and the current copayment amounts.

Table 7 South Carolina Department of Health and Human Services Copayment Amounts		
Service Category	Original Copayment Amount	Current Copayment Amount
Doctor office visits	\$2.00	\$3.30
Medical equipment	3.00	3.40
Chiropractor	1.00	1.15
Home health	2.00	3.30
Clinic visits	2.00	3.30
Prescription drugs	3.00	3.40
Inpatient hospital	25.00	25.00
Outpatient hospital other than emergency room	3.00	3.40

A Medicaid beneficiary may not be denied service if they are unable to pay the copayment at the time the service is rendered; however, this does not relieve the beneficiary of the responsibility for the copayment. The following beneficiaries do not have to make a copayment:

- > Children under 19 years of age
- > Pregnant women
- > Women receiving family planning services
- > Institutionalized individuals (such as persons in a nursing facility or an Intermediate Care Facility for the Mentally Retarded (ICF-MR))
- > Individuals receiving emergency services in the Emergency Room
- > Individuals receiving the Medicaid hospice benefit
- > Members of a Federally Recognized Indian Tribe are exempt from most co-payments. Tribal members are exempt when services are rendered by the Catawba Service Unit in Rock Hill, South Carolina and when referred to a specialist or other medical provider by the Catawba Service Unit.

We used information from the July 2011 – March 2012 MCO capitation rate calculation to develop an adjustment factor for the April 2010 – March 2011 experience data to reflect copay collection. We used the fee-for-service copay collection rate coupled with the current copayment amounts to develop paid to allowed ratios by major service category and rate cell. We used a similar methodology for the newly added MCO services.

We apply those adjustment factors to the encounter and fee-for-service base experience data to reflect estimated copayment collection by the MCOs.

Hospital Inpatient Reimbursement Adjustment:

On October 1, 2011, SC DHHS moved to a new method of paying for hospital inpatient services for the fee-for-service program. The new method is based on the All Patient Refined Diagnosis Related Groups (APR-DRGs). The goals of the change were to implement a new payment method that is sustainable and more appropriate to Medicaid using a modern DRG algorithm, that enables reduced payment for hospital-acquired conditions, and that simplifies the current payment method where appropriate. SC DHHS chose APR-DRGs because they are suitable for use with a Medicaid population, especially with regard to neonatal and pediatric care, and because they incorporate sophisticated clinical logic to capture the differences in comorbidities and complications that can significantly affect hospital resource use.

The basic approach for payment calculation is similar to the previous method: a DRG base payment is calculated by multiplying a relative weight for the specific DRG by a hospital-specific DRG discharge rate. The chief difference is that the DRG grouping system is APR-DRGs and not CMS-DRGs. Please refer to the “APR-DRG Pricing Calculator” on the SC DHHS website that shows detailed pricing calculations for more information (<http://www2.scdhhs.gov/resource/apr-drg>).

To develop the hospital inpatient reimbursement adjustment factors by rate cell, we repriced each hospital inpatient admission to 102% of the fee-for-service reimbursement amounts using the methodology documented in the “APR-DRG Pricing Calculator”. Our analysis is based on 100% of the total hospital inpatient claim dollars. The 102% of the fee-for-service reimbursement target recognizes that MCOs may contract with providers at rates higher than currently paid by Medicaid fee-for-service.

Table 8 below shows a summary of the impact of FFS repricing on the MCO encounter data by rate cell. On average, the impact is a reduction of 7.8%, with significant variation by rate cell based on the hospitals and APR-DRGs used by the MCO population in each rate cell.

Table 8 South Carolina Department of Health and Human Services Impact of FFS Repricing for Hospital Inpatient Services	
Rate Cell	Repricing Adjustment
TANF: 0 - 2 months old	5.6%
TANF: 3 - 12 months old	7.2%
TANF: Age 1 – 6	3.5%
TANF: Age 7 – 13	-2.9%
TANF: Age 14 - 18 Male	-6.0%
TANF: Age 14 - 18 Female	-10.5%
TANF: Age 19 - 44 Male	-20.8%
TANF: Age 19 - 44 Female	-19.6%
TANF: Age 45+	-25.2%
SSI – Children	9.1%
SSI – Adult	-15.9%
OCWI	-5.2%
Duals	N/A
Maternity Kicker Payment	-11.3%
Average Impact	-7.8%

Hospital Outpatient Reimbursement Adjustment:

To develop the hospital outpatient reimbursement adjustment factors by rate cell, we repriced each hospital outpatient case using the methodology documented in Section 4 of the Hospital Service Provider Manual (<http://www.scdhhs.gov/internet/pdf/manuals/Hospital/SECTION%204.pdf>).

We used the information provided by SC DHHS to sequentially identify the Reimbursement Type 1, 5, and 4 claims. We then applied 102% of the corresponding fee-for-service reimbursement amount, hospital multipliers, as well as add-on payments when appropriate. The 102% of the fee-for-service reimbursement target recognizes that MCOs may contract with providers at rates higher than currently paid by Medicaid fee-for-service.

For surgical claims, we used the supplied fee schedule to assign an all-inclusive rate that is specific to the procedure performed and resources used. Multiple surgeries pay the highest reimbursement amount. For non-surgical claims, we used the revenue code and diagnosis information to assign the correct all-inclusive rate. The repricing for other claims is based on revenue code and CPT code as documented in Section 4 of the Hospital Service Provider Manual. We then compared the repriced amounts to those found in the encounter data to derive the corresponding adjustment factor.

We excluded from our analysis the claims for which the repricing change was more than 100% above or 50% below the MCO paid amount. Overall, our analysis is based on 73% of the total Hospital Outpatient claim dollars.

Table 9 below shows a summary of the impact of FFS repricing on the MCO encounter data by rate cell. On average, the impact is a reduction of 12.0%, with variation by rate cell based on the services used by the MCO population in each rate cell.

Table 9	
South Carolina Department of Health and Human Services	
Impact of FFS Repricing for Hospital Outpatient Services	
Rate Cell	Repricing Adjustment
TANF: 0 - 2 months old	-8.0%
TANF: 3 - 12 months old	-13.9%
TANF: Age 1 – 6	-10.4%
TANF: Age 7 – 13	-10.8%
TANF: Age 14 - 18 Male	-11.8%
TANF: Age 14 - 18 Female	-12.6%
TANF: Age 19 - 44 Male	-12.9%
TANF: Age 19 - 44 Female	-14.4%
TANF: Age 45+	-7.8%
SSI – Children	-8.2%
SSI – Adult	-12.5%
OCWI	-12.6%
Duals	N/A
Maternity Kicker Payment	-5.7%
Average Impact	-12.0%

Physician and Other Services Reimbursement Adjustment:

For the physician and other services reimbursement adjustment, we did a complete repricing of the physician and ancillary claims data at 100% of the corresponding fee-for-service fee. We used the provider specialty information found on each claim to determine which fee schedule to apply from the various fee schedules available on the SC DHHS website (<http://www2.scdhhs.gov/resource/fee-schedules>).

We then compared the repriced amounts to those found in the encounter data to derive the corresponding adjustment factor by rate cell and service category. For the services where rates were not located in the fee schedules on DHHS’s website (such as anesthesiology, home visits, vision services, etc.), adjustments were developed using changes to FFS reimbursement from April 2010 – March 2011 to April 2012 to March 2013.

We excluded from our analysis the claims for which the repricing change was more than 100% above or 50% below the MCO paid amount. Overall, our analysis is based on 93% of the total physician claim dollars.

Table 10 below shows a summary of the impact of FFS repricing on the MCO encounter data by rate cell. On average, the impact is a reduction of 3.4%, with significant variation by rate cell based on the services used by the MCO population in each rate cell.

Table 10	
South Carolina Department of Health and Human Services	
Impact of FFS Repricing for Physician Services	
Rate Cell	Repricing Adjustment
TANF: 0 - 2 months old	1.1%
TANF: 3 - 12 months old	3.4%
TANF: Age 1 – 6	2.9%
TANF: Age 7 – 13	1.6%
TANF: Age 14 - 18 Male	-2.4%
TANF: Age 14 - 18 Female	-2.4%
TANF: Age 19 - 44 Male	-7.5%
TANF: Age 19 - 44 Female	-6.0%
TANF: Age 45+	-6.1%
SSI – Children	-1.2%
SSI – Adult	-7.0%
OCWI	-4.9%
Duals	N/A
Maternity Kicker Payment	-15.6%
Average Impact	-3.4%

Benefit Change Adjustment:

SC DHHS implemented several benefit limits effective February 1, 2011 that were implemented in the April 2011 – March 2012 MCO capitation rates. We developed adjustment factors to reflect those benefit limits because they are not fully reflected in the April 2010 – March 2011 base experience data. The benefit limits are as follows:

- > Diabetic shoes coverage will be limited to one pair per year instead of two. The limited benefits are identified using the following rule:
 - If provider type is equal to 76, and
 - If procedure code is equal to A5500, A5501, A5503, A5504, A5505, A5506, or A5507
- > Diabetic shoe inserts coverage will be reduced from six per year to three per year. The limited benefits are identified using the following rule:
 - If provider type is equal to 76, and
 - If procedure code is equal to A5512 or A5513
- > Power wheelchairs will be replaced every seven years instead of five. The limited benefits are identified using the following rule:
 - If provider type is equal to 76, and

- If procedure code is equal to K0813, K0814, K0815, K0816, K0820, K0821, K0822, K0823, K0824, K0825, K0827, K0828, K0829, K0835, K0836, K0837, K0841, K0842, K0843, K0848, K0849, K0850, K0851, K0852, K0853, K0856, K0857, K0858, K0859, K0860, K0861, K0862, K0863, K0864, K0868, K0869, K0870, K0871, K0877, K0878, K0879, K0880, K0884, K0885, K0886, K0890, or K0898
- > Adult pharmacy overrides will be reduced from four per month to three.
- > Home health visits reduced from 75 to 50 per year. This limit of 50 visits is effective for all beneficiaries including children under the age 21. The limited benefits are identified using the following rule:
 - If provider type is equal to 60, and
 - If procedure code is equal to T1030, T1031, T1028, T1021, S9127, S9128, S9129 or S9131
- > Combined total of 75 visits per year for private rehabilitative services (speech and language therapy, occupational therapy or physical therapy). The limited benefits are identified use the following rule:
 - If provider type is equal to 19 with practice specialty equal to 04, 84, 85 or 87 OR
 - If provider type is equal to 21 with practice specialty equal to 01, 04, 84, 85 or 87 OR
 - If provider type is equal to 22 with practice specialty equal to 04 or 89 AND
 - If procedure code is equal to 92507, 92508, 97110, 97530 or 97113
- > Chiropractic services reduced from 8 to 6 per year. The limited benefits are identified use the following rule:
 - If provider type is equal to 37 or 38, and
 - If practice specialty is equal to 7, and
 - If procedure code is equal to 98940, 98941, or 98942

For each individual, we summarized the count for each procedure and determined the impact of the limits by service category for each rate cell.

SC DHHS also implemented several changes to services covered by the MCOs effective February 1, 2011 that were implemented in the April 2011 – March 2012 capitation rates. We developed adjustment factors to reflect those benefit limits because they are not fully reflected in the April 2010 – March 2011 base experience data. The changes are as follows:

- > Podiatry services will be limited to beneficiaries under the age of 21. A new rule was added to the In-Rate Criteria as follows:
 - If provider type is equal to 35, and
 - If practice specialty code is equal to 47 then the claim is removed from the MCO rate calculation.
- > Vision services will be limited to beneficiaries under the age of 21. The services affected by this change include routine eye exams and refractions as well as eyeglasses that fall within the policy limitation. If determined to be medically necessary, these vision services will continue to be

covered for beneficiaries over the age of 21. Because of this change, a new rule was added to the In-Rate Criteria as follows:

- The logic necessary to determine whether this is a routine exam or a medically necessary procedure applies to provider types and practice specialties of 20 / 31, 32 / 33, 41 / 33, 33 / 34, 34 / 34
 - The procedure codes for routine exams and refractions are as follows: 92012, 92014, 92015, 92004, 99201, 99202, 99203, 99204, 99205, 99211, 99212, 99213, 99214, 99215
 - If the following diagnosis codes occur on a claim with the above procedure codes, the procedures will not be considered medically necessary and the claim should not be paid for beneficiaries over the age of 21: 367.0, 367.1, 367.2, 367.20, 367.21, 367.22, 367.3, 367.31, 367.32, 367.4, 367.5, 367.51, 367.52, 367.53, 367.8, 367.81, 367.89, 368.13
- > Newborn circumcisions are no longer covered. Because of this change, a new rule was added to the In-Rate Criteria as follows:
- If provider type is equal to 20 or 21, and
 - If CPT code is equal to 54150 and 54160 then the claim is removed from the MCO rate calculation.
- > Coverage of insulin pumps for Type II diabetics is discontinued. Because of this change, a new rule was added to the In-Rate Criteria as follows:
- If provider type equals 76,
 - If procedure code is equal to E0784 then the claim is removed from the MCO rate calculation.
- > Coverage of wheelchair accessories such as umbrella holders, pillows, crutch / cane holders, and similar accessories is discontinued. Because of this change, a new rule was added to the In-Rate Criteria as follows:
- If provider type equals 76,
 - If procedure code is equal to K0180 or E1399 then the claim is removed from the MCO rate calculation.
- > Coverage of Syvek patch is discontinued. Because of this change, a new rule was added to the In-Rate Criteria as follows:
- If provider type equals 22,
 - If practice specialty code is equal to 21, and
 - If procedure code is equal to A4913 then the claim is removed from the MCO rate calculation.

The cost impact of this adjustment varies from 0.982 to 1.000 for the various TANF rate cells, between 0.984 and 1.000 for SSI, between 0.993 and 1.000 for Duals, and between 0.997 and 1.000 for OCWI.

The cost impact of these combined adjustments is shown in Appendices B1-B4.

MCO Selection Adjustment:

The MCO selection adjustment modifies the base data to the morbidity level of the population anticipated to be enrolled in MCOs during the contract period. Based on analysis of Medicaid Rx risk scores and our experience in other states with voluntary managed care enrollment, we calculated selection adjustments shown in Table 11. Milliman will provide a separate letter documenting the calculation of the selection adjustments.

Table 11 South Carolina Department of Health and Human Services MCO Selection Adjustment	
Rate Cell	Adjustment
TANF: 0 - 2 months old	1.000
TANF: 3 - 12 months old	1.000
TANF: Age 1 – 6	1.040
TANF: Age 7 – 13	1.040
TANF: Age 14 - 18 Male	1.040
TANF: Age 14 - 18 Female	1.040
TANF: Age 19 - 44 Male	1.064
TANF: Age 19 - 44 Female	1.064
TANF: Age 45+	1.064
SSI – Children	1.010
SSI – Adult	0.990
OCWI	1.000
Duals	1.000
Maternity Kicker Payment	1.000

Trend April 2010 – March 2011 to April 2012 – March 2013:

Because the Medicaid managed care capitation rate methodology adjusts the average charge per service for medical services to current reimbursement levels, we applied a utilization trend only for non-pharmacy services. We applied a PMPM cost trend to prescription drug services.

Trend rates from April 2010 – March 2011 to April 2012 – March 2013 were derived from SC DHHS quarterly budget projections. We did not have a long enough credible encounter data experience period to develop annual trend rates from the encounter data.

Table 12 below summarizes the estimated annual trend rates by major service category for the Medicaid managed care program eligible populations.

Table 12
South Carolina Department of Health and Human Services
Annual Trend Assumptions

Service Category	Hospital Inpatient¹	Hospital Outpatient¹	Physician¹	Radiology and Pathology¹	Prescription Drugs²	Other¹
TANF Infants	0.0%	2.0%	2.0%	2.0%	5.0%	2.0%
TANF Children	0.0%	2.0%	2.0%	2.0%	5.0%	2.0%
TANF Adults	0.0%	2.0%	2.0%	2.0%	5.0%	2.0%
SSI Children	0.0%	2.0%	2.0%	2.0%	5.0%	2.0%
SSI Adult	0.0%	2.0%	2.0%	2.0%	5.0%	2.0%
OCWI	0.0%	2.0%	2.0%	2.0%	5.0%	2.0%
Duals	0.0%	2.0%	2.0%	2.0%	5.0%	2.0%
Maternity Kick	0.0%	2.0%	2.0%	N/A	N/A	N/A

¹ Utilization trend only

² PMPM cost trend

Additional Managed Care Savings Adjustment:

In July 2011, SC DHHS implemented various utilization controls and increased care management activities from which additional savings are expected. The April 2012 – March 2013 capitation rates assume the following cost savings beyond the medical management efficiency level underlying the April 2010 – March 2011 MCO encounter data :

- > A 10.0% savings on hospital inpatient costs for infants. The savings is based on new initiatives to reduce the NICU / PICU average length of stay.
- > A 0.5% savings on hospital inpatient costs due to new initiatives to reduce hospital inpatient readmissions.
- > A 2.0% savings on hospital inpatient maternity costs due to preauthorization for any C-sections or inductions prior to 39 weeks. The 2% reduction reflects the estimated reduction in the cost per admission due to a reduction in the rate of C-sections and inductions.

In addition to the July 2011 savings initiatives, the April 2012 – March 2013 capitation rates assume further efficiency improvement of 0.5% for all medical and pharmacy services.

Appendices B1 and B2 reflect the impact of the changes listed above for the appropriate rate cells.

In Appendices B3 and B4, we applied managed care savings adjustment factors to the services previously paid on a fee-for-service basis. The managed care savings adjustments applied to fee-for-service data are consistent with previous years' rate development using fee-for-service data.

Non-Claim Payments Adjustment:

We made an adjustment to the encounter data base experience period to reflect non-claim payments made to providers for items such as shared savings payments, quality incentives, and other provider payments not included in the encounter data. In total, the plans reported an additional \$2.6 million in non-claim payments made to providers. We used this information to develop a global adjustment factor of 0.2% that we uniformly applied to each service category and rate cell in Appendix B1.

Step 3: Calculate Estimated April 2012 – March 2013 Managed Care Costs and Adjust for Administrative Expenses and Supplemental Teaching Payments

Calculate Estimated April 2012 – March 2013 Managed Care Costs:

The estimated April 2012 – March 2013 managed care cost is comprised of four separate components:

- > The projected cost for the core MCO covered services during the April 2010 – March 2011 experience period,
- > For the Standard benefit package only, the projected cost for the family planning MCO covered services during the April 2010 – March 2011 experience period
- > The projected cost for the newly covered MCO services that were covered through the fee-for-service system during the April 2010 – March 2011 experience period, and
- > The projected cost for the expanded LTC services from the April 2010 – March 2011 experience period for expanded the MCO liability from 30 days to 90 days of a nursing home stay.

For both Standard and Ethically Limited benefit packages, the projected cost for core and newly covered services from Appendices B1, B3, and B4 are added together and reported under the April 2012 – March 2013 Projected PMPM Costs in Appendices D1 and D2. For the Standard benefit package, we add the projected cost for the family planning services as a Family Planning Add-On from Appendix B2.

Administration:

Table 13 shows the administrative allowances for medical and pharmacy services by rate cell as a percentage of capitation revenue (excluding the supplemental teaching pass-through):

Table 13 South Carolina Department of Health and Human Services Administrative Allowance as a Percent of Revenue Excluding Supplemental Teaching Payments	
Rate Cell	Administrative Allowance
TANF: 0 - 2 months old	9.5%
TANF: 3 - 12 months old	9.5%
TANF: Age 1 - 6	9.5%
TANF: Age 7 - 13	9.5%
TANF: Age 14 - 18 Male	9.5%
TANF: Age 14 - 18 Female	11.5%
TANF: Age 19 - 44 Male	9.5%
TANF: Age 19 - 44 Female	11.5%
TANF: Age 45+	9.5%
SSI – Children	9.5%
SSI – Adult	9.5%
OCWI	11.5%
Duals	Set equal to SSI
Maternity Kicker Payment	4.5%

The total administration allowance is 9.5% of the final capitation rates excluding the supplemental teaching payment pass-through. The administrative allowance is consistent with industry benchmarks and MCO experience.

The details of our calculations are shown in Appendices D1 and D2.

Supplemental Teaching Payments:

SC DHHS provided the most recent lists of teaching physicians eligible for Medicaid Enhanced Payments. We used these lists to compile all encounter data claims for each of the providers and calculated the Supplemental Teaching Payments as 35% of billed charges with total payment per claim not to exceed total billed charges. The Supplemental Teaching Payment calculation procedure is summarized below:

1. Summarize the April 2010 – March 2011 Supplemental Teaching Payments for the listed providers by eligibility category.
2. Project to April 2012 – March 2013 using the following adjustments:
 - > Utilization trend at the same rates used for the MCO covered services in Table 12.
 - > Billed charge trend of 4%.
 - > The MCO selection adjustments shown in Table 11.
 - > IBNR adjustment.
 - > Professional managed care adjustment to the Dual rate cell only.

The Supplemental Teaching Payments are calculated in Appendices C1 – C2

Step 4: Adjust TANF and SSI Rate for MCO Specific Risk Score

The Medicaid managed care capitation rate methodology includes a risk adjustment component to account for the difference in morbidity among MCOs for the TANF and SSI eligibility category.

Risk adjusted payments are more accurate and appropriate than paying a fee-for-service average by age and gender and eligibility category. With risk adjusted payments, MCOs can expect to be reimbursed based on the level of need of their Medicaid beneficiaries. In such an environment, MCOs can expect that they will be rewarded for designing better services and delivering them more efficiently for people with any kind of condition or level of need, including those with complex conditions and high levels of need. The implementation of a risk adjustment process should minimize the effect of anti-selection.

We recommended the implementation of the Restricted Medicaid Rx model for the determination of risk adjustment. This recommendation is based upon the current limited availability of complete and credible diagnosis information through encounter data.

Medicaid Rx is a pharmacy based diagnosis system developed by the researchers at the University of California, San Diego (UCSD). Medicaid Rx is a standalone pharmacy-based methodology and was not combined with the diagnosis based risk adjustment system. The Restricted Medicaid Rx model excludes prescriptions for GAD (Gastric Acid Disorder), folate and iron deficiency anemias, EENT (Eyes, ears,

nose, and throat), insomnia, pain, and low-cost infections. These categories of drugs, as identified by UCSD researchers, may be susceptible to gaming and their inclusion in a risk adjustment model might create an incentive for over prescribing. The risk score calculation also excluded the Depression / Anxiety and Psychotic Illness / Bi-polar disease categories. These disease categories were excluded since mental health services are not covered by the managed care plans.

The TANF 0 - 2 months and 3 - 12 months rate cells are not risk adjusted using Medicaid Rx.

An MCO's TANF and SSI capitation rate will be determined based on the following formula for each rate cell:

$$\text{MCO Capitation Rate} = \text{Base Capitation Rate} \times \text{MCO Adjusted Risk Factor}$$

The composite of the MCO Adjusted Risk Factors for all MCOs will be 1.000.

Milliman will issue a separate letter documenting the development of the MCO Adjusted Risk Factors that will be applied to the April 2012 – March 2013 TANF and SSI capitation rates.

MATERNITY KICKER PAYMENT

The Maternity Kicker Payment (MKP) includes all facility and professional claims associated with deliveries. The facility charges for deliveries that include sterilization are included in the MKP for the standard benefit package only.

MKP cases are counted as women who have either a maternity delivery DRG or a physician maternity delivery claim (or both). The case counting logic is consistent with how SC DHHS administers the MKP. The MKP cases are distributed in the following manner:

- > Both a maternity delivery DRG and a physician claim = 91%
- > A maternity delivery physician claim only = 5%
- > A maternity delivery DRG only = 4%

We used the following criteria to identify claims information to calculate the MKP. The MKP includes hospital inpatient delivery services, hospital outpatient and emergency room delivery services as well as professional delivery services. Delivery with sterilization services are only included in the standard benefit package rate.

- > Hospital Inpatient providers, with DRG codes of 370 – 375
- > Hospital Outpatient providers with a primary diagnosis code of v27.0 – v27.9, 650, and 651.01 - 669.92 (with the 5th digit being 1 or 2) and reimbursement type equal to 1

For the following providers, only delivery services are included (CPT codes 59409, 59514, 59612, 59620, 00850, 00857, 00946, 00955, 01960, 01961, 01967, and 01968)

- > Physician providers
- > Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs)

- > Department of Health and Environmental Control (DHEC)
- > Federally Funded Health Clinics (FFHC)
- > Nurse Midwife and Nurse Practitioner

The Maternity Kicker Payment is developed consistent with the methodology outlined in Steps 1 through 4 in Section III of this report.

IV. SERVICE CATEGORY ASSIGNMENT

This section of the report provides information about the service category assignment used to create the cost models included in the South Carolina Medicaid managed care capitation rate development. This information can be used by participating MCOs to monitor their experience in a format and detail similar to the rate development process. MCOs are encouraged to monitor their emerging experience and take corrective actions when necessary.

To prepare the attached cost models, we grouped claims into the same categories as used in the quarterly CRCS reporting process.

HOSPITAL INPATIENT

Hospital inpatient services are those items and services, provided under the direction of a physician, furnished to a patient who is admitted to a general acute care medical facility for facility and professional services on a continuous basis that is expected to last for a period greater than 24 hours. An admission occurs when the Severity of Illness / Intensity of Services criteria set forth by the review contractor and approved by SC DHHS is met. Among other services, hospital inpatient services encompass a full range of necessary diagnostic, therapeutic care including surgical, medical, general nursing, radiological, and rehabilitative services in emergency or non-emergency conditions. Additional hospital inpatient services would include room and board, miscellaneous hospital services, medical supplies, and equipment.

The hospital inpatient claims are assigned a service category based on Diagnostic Related Group (DRG) codes. Milliman's algorithm classifies hospital inpatient claims using the following groupings of 2007 DRG codes.

Table 14 South Carolina Department of Health and Human Services Hospital Inpatient Service Groupings by DRG Code	
Service Category	Diagnostic Related Group
Medical / Surgical / Non-Delivery	001 - 003, 006 - 019, 021 - 023, 026 - 106, 108, 110 - 111, 113 - 114, 117 - 147, 149 - 153, 155 - 208, 210 - 213, 216 - 220, 223 - 230, 232 - 369, 376 - 390, 392 - 399, 401 - 414, 417 - 424, 439 - 455, 461 - 468, 471, 473, 476 - 477, 479 - 482, 484 - 513, 515, 518 - 520, 524 - 525, 528 - 579
Maternity	425 - 433, 521 - 523
Mental Health / Substance Abuse	370 - 375
Maternity	391
Well Newborn	004 - 005, 020, 024 - 025, 107, 109, 112, 115 - 116, 148, 154, 209, 214 - 215, 221 - 222, 231, 400, 415 - 416, 434 - 438, 456 - 460, 469 - 470, 472, 474 - 475, 478, 483, 514, 516 - 517, 526 - 527
Other Inpatient	

HOSPITAL OUTPATIENT

Hospital outpatient services are defined as those preventive, diagnostic, therapeutic, rehabilitative, surgical, and emergency services received by a patient through an outpatient / ambulatory care facility for the treatment of a disease or injury for a period of time generally not exceeding 24 hours. Outpatient /

ambulatory care facilities include hospital outpatient departments, diagnostic / treatment centers, ambulatory surgical centers, emergency rooms, end stage renal disease (ESRD) clinics, and outpatient pediatric AIDS clinics (OPAC). Costs include facility charges only and do not include professional charges unless performed by staff of the facility and billed on a UB-92 (hospital) claims form. All facility-billed items not part of an inpatient admission are considered hospital outpatient services.

The hospital outpatient claims are assigned a service category based on revenue codes. Milliman's algorithm classifies hospital outpatient claims using the following groupings of revenue codes.

Table 15 South Carolina Department of Health and Human Services Hospital Outpatient Service Groupings by Revenue Code	
Service Category	Revenue Code
Emergency Room	'0450' - '0451', '0681' - '0689', '0981'
Surgery	'0360' - '0369', '0490' - '0499', '0790' - '0799', '0975'
Non Surgery	'0510' - '0519', '0761'
Observation Room	'0762', '0769'
	'0170' - '0171', '0258', '0260' - '0261', '0300' - '0302', '0304' - '0307', '0309' - '0312', '0314', '0319', '0320' - '0324', '0329' - '0333', '0335', '0340' - '0343', '0349' - '0352', '0359', '0380' - '0387', '0390' - '0391', '0400' - '0403', '0410', '0412', '0413', '0419' - '0420', '0424', '0430', '0434', '0440', '0444', '0459' - '0460', '0469' - '0472', '0479' - '0483', '0489', '0610' - '0612', '0614' - '0616', '0618' - '0619', '0634' - '0636', '0721', '0730' - '0732', '0739', '0740', '0749' - '0750', '0759', '0820' - '0821', '0830' - '0831', '0840' - '0841', '0850' - '0851', '0900' - '0901', '0910', '0914' - '0916', '0918', '0920' - '0924', '0929', '0940', '0943'
Treatment / Therapy / Testing	
Other Outpatient	All other

PROFESSIONAL

Professional services include the full range of preventive care services, primary care medical services and physician specialty services. All services must be medically necessary and appropriate for the treatment of a specific diagnosis, as needed for the prevention, diagnostic, therapeutic care, and treatment of the specific condition. Physician services are performed at physician's offices, patients' homes, clinics, and skilled nursing facilities. Technical services performed in a physician's office are considered part of the professional services delivered in an ambulatory setting unless designated as a separate service.

Physician services are assigned to a service category using Current Procedural Terminology (CPT) codes. Place-of-service information is used to assign surgery codes to the inpatient or outpatient categories.

PHARMACY

The pharmacy category includes pharmaceuticals as ordered by licensed prescribers and obtained at an outpatient pharmacy. Prescription drugs are identified by the presence of a National Drug Code (NDC) in the claims file.

OTHER

The other service category includes the following services:

- > Home health services including intermittent skilled nursing, home health aide, physical, occupational and speech therapy services, and physician ordered supplies.
- > Emergency transportation or acute care situation where normal transportation would potentially endanger the life of the patient.
- > Durable medical equipment that provides therapeutic benefits or enables a recipient to perform certain tasks that he or she would be unable to undertake otherwise due to certain medical conditions and / or illnesses.
- > Hearing aids and hearing aid accessories.
- > Dental services.

Other services are also assigned a service category using CPT codes. Other, unidentifiable services are assigned an “unknown” category of service.

V. CMS RATE SETTING CHECKLIST ISSUES

This section of the report lists each item in the CMS checklist and either discusses how SC DHHS addresses each issue or directs the reader to other parts of this report. CMS uses the rate setting checklist to review and approve a state's Medicaid capitation rates.

AA.1.0 – Overview of Rate Setting Methodology

The MCO capitation rates are developed using South Carolina MCO encounter data and fee-for-service Medicaid data for the MCO population. SC DHHS calculates State-set rates by rate category on a statewide basis. Please refer to Section III of this report for more details.

AA.1.1 – Actuarial Certification

Please refer to Appendix I for our actuarial certification of the April 2012 – March 2013 capitation rates. The April 2012 – March 2013 South Carolina Medicaid managed care capitation rates have been developed in accordance with generally accepted actuarial principles and practices and are appropriate for the populations to be covered and the services to be furnished under the contract.

AA.1.2 – Projection of Expenditures

Appendix H includes a projection of total expenditures and Federal-only expenditures based on actual October 2011 MCO enrollment, July 2011 – March 2012 capitation rates and April 2012 – March 2013 capitation rates. We used a 70.24% FMAP rate to calculate the Federal expenditures.

AA.1.3 – Procurement, Prior Approval, and Rate Setting

SC DHHS develops state set rates. Please refer to Section III of this report for details.

Note – There is No Item AA.1.4 in the Checklist

AA.1.5 – Risk Contracts

The South Carolina Medicaid managed care program meets the criteria of a risk contract.

AA.1.6 – Limit on Payment to Other Providers

It is our understanding no payment is made to a provider other than the participating MCOs for services available under the contract.

AA.1.7 – Rate Modifications

The April 2012 – March 2013 rates documented in this report are the initial capitation rates for the April 2012 – March 2013 Medicaid managed care contracts.

AA.2.0 – Base Year Utilization and Cost Data

The April 2012 – March 2013 rate methodology relies on April 2010 – March 2011 MCO encounter data as the primary data source. We also used April 2010 – March 2011 FFS data for MCO enrollees for services that were not part of the MCO contract during the April 2010 – March 2011 base period and to develop the dual eligible rate.

Only State Plan services that are covered under the South Carolina Medicaid managed care contract have been included in the rate development.

AA.2.1 – Medicaid Eligibles Under the Contract

Data for populations not eligible to enroll in the South Carolina Medicaid managed care program has been excluded from the base data used in rate development.

AA.2.2 – Dual Eligibles

The rate structure includes a rate cell that only applies to individuals who receive retroactive Medicare eligibility while enrolled in an MCO. The Dual Eligible rate cell includes all Medicaid services and Medicare crossover claims payments that are the responsibility of the MCOs for a dually eligible individual.

AA.2.3 – Spend Down

The spend down population is excluded from the Medicaid managed care program and the capitation rate development.

AA.2.4 – State Plan Services Only

The base utilization and cost data is April 2010 – March 2011 encounter and fee-for-service data and includes only State Plan services.

AA.2.5 – Services that may be Covered by a Capitated Entity Out of Contract Savings

Services that may be covered by a capitated entity out of contract savings are not included in the data used to develop the April 2012 – March 2013 capitation rates.

AA.3.0 – Adjustments to Base Year Data

All adjustments to the base year data are discussed in Section III of this report. In addition, each item in the checklist is addressed in items AA.3.1 – AA.3.14 below.

AA.3.1 – Benefit Differences

The base data used to calculate the capitation rates has been adjusted to only include services covered under the managed care contract.

AA.3.2 – Administrative Cost Allowance Calculations

The MCO capitation rates include explicit administrative allowances by rate cell. Please see Section III of the report for more details regarding the administrative cost calculation.

AA.3.3 – Special Population Adjustments

The fee-for-service base data used to calculate the capitation rates is consistent with the managed care population. No special population adjustment was necessary.

AA.3.4 – Eligibility Adjustments

SC DHHS uses a selection adjustment to adjust the base data to the morbidity level of the population anticipated to be enrolled in MCOs during the contract period.

AA.3.5 – DSH Payments

DSH payments are not included in the capitation rates.

AA.3.6 – Third Party Liability (TPL)

The managed care organizations are responsible for the collection of any TPL recoveries. The MCO encounter data is reported net of TPL recoveries, therefore no adjustment was necessary.

AA.3.7 – Copayments, Coinsurance, and Deductibles in Capitated Rates

The South Carolina Medicaid managed care program includes member cost sharing. An adjustment was applied to the encounter data to reflect current member cost sharing amounts.

AA.3.8 – Graduate Medical Education (GME)

GME payments were removed from the base data in the capitation rate calculation.

AA.3.9 – FQHC and RHC Reimbursement

FQHC and RHC services are repriced to current fee-for-service rates.

AA.3.10 – Medical Cost Trend Inflation

The inflation factors used to project expenditures from April 2010 – March 2011 to April 2012 – March 2013 are based on inflation factors used for South Carolina's Medicaid budget projection.

We are comfortable that the trend rates and inflation factors represent the expected change in per capita cost between April 2010 – March 2011 and April 2012 – March 2013.

AA.3.11 – Utilization Adjustments

Utilization trend is included in AA.3.10.

AA.3.12 – Utilization and Cost Assumptions

TANF and SSI populations will use the Medicaid Rx risk adjuster to adjust the rates for each participating MCO. Medicaid Rx uses recipients' prescription drug usage information to develop a risk score for each individual. Section III explains how the risk scores are calculated and applied to the participating MCOs' rates for the TANF and SSI populations.

AA.3.13 – Post-Eligibility Treatment of Income (PETI)

Not applicable.

AA.3.14 – Incomplete Data Adjustment

The capitation rates include an adjustment to reflect IBNR claims. Please refer to Section III of this report for more information on the development of these adjustment factors.

AA.4.0 – Establish Rate Category Groupings

Please refer to Section III of this report.

AA.4.1 – Age

Please refer to Section III of this report.

AA.4.2 – Gender

Please refer to Section III of this report.

AA.4.3 – Locality / Region

Region is not used as a rating variable.

AA.4.4 – Eligibility Categories

Please refer to Section III of this report.

AA.5.0 – Data Smoothing

We did not perform any data smoothing.

AA.5.1 – Special Populations and Assessment of the Data for Distortions

We did not identify any material distortions caused by special populations.

AA.5.2 – Cost-Neutral Data Smoothing Adjustment

We did not perform any data smoothing.

AA.5.3 – Risk Adjustment

The April 2012 – March 2013 capitation rates for the TANF and SSI populations will use the Medicaid Rx risk adjuster to adjust the rates for each participating MCO. Medicaid Rx uses recipients' prescription drug usage information to develop a risk score for each individual. Section III explains how the risk scores are calculated and applied to the participating MCOs' rate for the TANF and SSI populations.

Milliman will provide a separate letter documenting the development of the MCO Adjusted Risk Factors that will be applied to the April 2012 – March 2013 TANF and SSI capitation rates.

AA.6.0 – Stop Loss, Reinsurance, or Risk Sharing Arrangements

None

AA.6.1 – Commercial Reinsurance

SC DHHS does not require entities to purchase commercial reinsurance.

AA.6.2 – Simple Stop Loss Program

None

AA.6.3 – Risk Corridor Program

None

AA.7.0 – Incentive Arrangements

SC DHHS has implemented a withhold and incentive arrangement for the contract period of April 2012 through March 2013. The terms of the withhold and incentive arrangement are outlined in the contract with the MCOs. The incentive will not exceed 105% of the capitation rates. The withhold and incentive are based on an actuarially sound methodology and will be based on the provisions of the contract. The capitation rates shown in this report do not reflect the withhold provision. Withhold payments will be available to both private and public contractors, and will not be conditioned upon intergovernmental transfer agreements. Withhold payments will be reviewed on an annual basis, and will not be renewed automatically.

APPENDIX A - E

State of South Carolina Department of Health and Human Services April 2012 – March 2013 Capitation Rate Development for the Medicaid Managed Care Program

State of South Carolina Department of Health and Human Services

April 2012 – March 2013 Capitation Rate Development for Medicaid Managed Care Program

March 26, 2013

This report assumes that the reader is familiar with the State of South Carolina's Medicaid program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to SC DHHS to set April 2012 – March 2013 capitation rates for the Medicaid MCO program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

APPENDIX F - G

State of South Carolina
Department of Health and Human Services
April 2012 – March 2013
Capitation Rate Components

State of South Carolina Department of Health and Human Services
April 2012 – March 2013 Capitation Rate Development for Medicaid Managed Care Program

March 26, 2013

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APPENDIX H

State of South Carolina
Department of Health and Human Services
April 2012 – March 2013
Fiscal Impact Exhibit

State of South Carolina Department of Health and Human Services
April 2012 – March 2013 Capitation Rate Development for Medicaid Managed Care Program

March 26, 2013

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APPENDIX I

State of South Carolina Department of Health and Human Services April 2012 – March 2013 Actuarial Certification

State of South Carolina Department of Health and Human Services

April 2012 – March 2013 Capitation Rate Development for Medicaid Managed Care Program

March 26, 2013

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March 26, 2013

South Carolina Department of Health and Human Services
Capitated Contracts Ratesetting
Actuarial Certification
April 2012 – March 2013 Medicaid Managed Care Capitation Rates

I, John D. Meerschaert, am associated with the firm of Milliman, Inc., am a member of the American Academy of Actuaries, and meet its Qualification Standards for Statements of Actuarial Opinion. I was retained by the South Carolina Department of Health and Human Services (SC DHHS) to perform an actuarial certification of the Medicaid managed care capitation rates for April 2012 – March 2013 for filing with the Centers for Medicare and Medicaid Services (CMS). I reviewed the capitation rates development and am familiar with the Code of Federal Regulations, 42 CFR 438.6(c) and the CMS “Appendix A, PAHP, PIHP and MCO Contracts Financial Review Documentation for At-risk Capitated Contracts Ratesetting.”

I examined the actuarial assumptions and actuarial methods used in setting the capitation rates for April 2012 – March 2013. To the best of my information, knowledge and belief, for the period from April 2012 – March 2013, the capitation rates offered by SC DHHS are in compliance with 42 CFR 438.6(c). The attached actuarial report describes the capitation rate setting methodology.

In my opinion, the capitation rates are actuarially sound, were developed in accordance with generally accepted actuarial principles and practices, and are appropriate for the populations to be covered and the services to be furnished under the contract.

In making my opinion, I relied upon the accuracy of the underlying claims and eligibility data records and other information. A copy of the reliance letter received from SC DHHS is attached and constitutes part of this opinion. I did not audit the data and calculations, but did review them for reasonableness and consistency and did not find material defects. In other respects, my examination included such review of the underlying assumptions and methods used and such tests of the calculations as I considered necessary.

Actuarial methods, considerations, and analyses used in forming my opinion conform to the appropriate Standards of Practice as promulgated from time-to-time by the Actuarial Standards Board, whose standards form the basis of this Statement of Opinion.

State of South Carolina Department of Health and Human Services
April 2012 – March 2013 Capitation Rate Development for Medicaid Managed Care Program

March 26, 2013

This report assumes that the reader is familiar with the State of South Carolina’s Medicaid program, its benefits, and rate setting principles. The report was prepared solely to provide assistance to SC DHHS to set April 2012 – March 2013 capitation rates for the Medicaid MCO program. It may not be appropriate for other purposes. Milliman does not intend to benefit and assumes no duty or liability to other parties who receive this work. This material should only be reviewed in its entirety.

South Carolina Department of Health and Human Services
Capitated Contracts Ratesetting
Actuarial Certification
April 2012 – March 2013 Medicaid Managed Care Capitation Rates
March 26, 2013
Page 2

It should be emphasized that capitation rates are a projection of future costs based on a set of assumptions. Actual costs will be dependent on each contracted managed care organization's situation and experience.

This Opinion assumes the reader is familiar with the South Carolina Medicaid program, Medicaid managed care programs, and actuarial rating techniques. The Opinion is intended for the State of South Carolina and the Centers for Medicare and Medicaid Services and should not be relied on by other parties. The reader should be advised by actuaries or other professionals competent in the area of actuarial rate projections of the type in this Opinion, so as to properly interpret the projection results.



John D. Meerschaert
Member, American Academy of Actuaries

March 26, 2013
